



PCG REFERRAL
*** CONFIDENTIAL ***

Prenatal Care Guidance Program
Family, Maternal and Child Health Programs

East Fax: (925) 313-6708
West Fax: (510) 231-8505
Central Fax: (925) 313-6708

☐ **URGENT**

PATIENT LAST NAME _____ **FIRST NAME** _____

EDD _____

DOB _____ **SS#** _____ **Medical Record #** _____

Address _____ **Phone #** _____

Message # _____

Language: ☐ Spanish ☐ English ☐ Other _____

Insurance (check all that apply): ☐ Medi-Cal (fee for service) ☐ CCHP ☐ Blue Cross ☐ None

Additional Sources of Care _____

Additional Diagnoses _____

FROM: Agency/ Program _____ **Date** _____

Referred By _____ **Phone** _____ **Fax** _____

Reason for Referral (medical/social) – please attach any necessary documents

☐ First time missed appointment ☐ # missed appointments _____

☐ Other reasons/comments _____

Date of First Prenatal Appointment _____ **Appointment Kept** ☐ Yes ☐ No

Date Patient Last Seen _____ **By Whom** _____

Next Appointment With _____ **Date** _____

OUTREACH WORKER RESPONSE

SUMMARY

- | | | |
|--|---|--|
| <input type="checkbox"/> Unable to locate | <input type="checkbox"/> Patient contacted/appointment made | <input type="checkbox"/> Patient transferred care |
| <input type="checkbox"/> Patient moved | <input type="checkbox"/> Patient contacted (see comments) | <input type="checkbox"/> Patient refused follow-up |
| <input type="checkbox"/> Patient had: TAB / SAB (circle one) | | |

DISPOSITION

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> Put in caseload | <input type="checkbox"/> Continue to locate | <input type="checkbox"/> Closed |
|--|---|---------------------------------|

COMMENTS _____

Signature _____ **Phone** _____ **Date** _____

For additional forms, please call
(925) 313-6254

Key: tv = telephone visit hv = home visit nhv = not home visit
ov = office visit ml = mail letter tib = telephone in behalf